NOTE: This document is not final and may change. Please refer back frequently.

--Draft--Co-Occurring Disorders (COD) Module Implementation: Frequently Asked Questions

1. Q: Where can I find the 9-point COD module?

A: The 9 Point COD module is available on the Office of the Medical Director's Home page, which can be accessed through the DMH internet ('Office of the Medical Director'). Here's the address: www.rshaner.medem.com.

2. Q: Where can I find the COD forms?

A. The new COD forms, the Supplemental Co-Occurring Disorders Assessment Checklist, the Supplemental Co-Occurring Disorders Re-Assessment checklist and the Co-Occurring Disorders Supplemental Treatment Planning documents are available on the DMH intranet website. First select 'HIPAA" then 'FORMS'. There is a Co-occurring Disorders Section under Clinical Forms.

3. Q: When will we begin using these forms?

A: May 3.

4. Q: Where do the forms get filed in the chart?

A. All **new clients** will be admitted using a new 8-part chart that has a unique section for Co-Occurring Disorders (COD) forms. **Readmissions** with a current co-occurring disorder should, on admission, have their record either converted to an 8-part chart or start a Vol 2, 8-part chart. If a Vol 2 is started, bring forward from the 6-part chart all information within the last six months that is pertinent to current treatment. **Current clients** with a current substance use problem should have their records converted to an 8-part chart as soon as possible. If this cannot be done at the time the new COD forms are implemented for a client, the forms may be filed in the Assessment Section of the existing record until such time as an 8-part record is created. As with readmissions, the contents of a 6-part record may be brought forward in their entirety in accord with the 8-part chart order or a Vol 2 may be created, bringing forward all information within the last six months that is pertinent to current treatment.

5. Q: Who completes the forms?

A: Licensed or waivered/registered clinicians, substance abuse counselors, and medical caseworkers. Other staff members may also complete the forms, as approved by the program manager on a case-by-case basis. (8/2/04)

6. Q: What does the abbreviation PPD mean?

A: In the context of co-occurring disorders, packs (cigarettes) per day.

7. Q: What does OZ/D mean?

A: Ounces of alcoholic drink per day. 12 ounces of beer contains the equivalent amount of alcohol typically as 4 ounces of wine or 1 ounce of liquor.

8. Q: How often is the reassessment to be completed?

A: The reassessment should be completed either monthly or at each appointment whichever is the longest interval. The reassessment should also be completed whenever there is a significant change in use, stage of readiness for change, motivation, or impact on mental health symptoms. Corresponding documentation in the progress note should reflect an assessment of BOTH mental health and substance use.

9. Q: The initial general mental health assessment form (adult initial assessment) has a substance abuse section (page 3). Do I fill out both the COD Supplemental Assessment form and this section?

A: If current substance abuse is identified on the substance abuse section of the adult initial assessment (MH 532), the Department requires you to complete the COD Supplemental Assessment form but NOT page 3 (section VI Substance use/Abuse of MH 532) of the adult initial assessment. However, you may wish to complete parts that are clinically relevant. Program managers may choose to require their staff to complete the entire section VI Substance use/Abuse of MH 532. If you do not fill out the adult initial assessment write, "see COD Initial Assessment form." Complete the entire COD Supplemental Assessment form for anyone with current substance use problems. If no current substance abuse is identified on the adult initial assessment, do not use the COD Supplemental Assessment form.

10. Q: If a client is using multiple substances, do I fill out COD forms for each substance?

A: No, choose the substance that currently has the greatest impact on the client's mental health and focus your assessments on abuse of that substance.

11. Q: How are Healthy Living Groups to be documented and billed?

A: Documentation must reflect what happened in the session, referring specifically to the skill development that was a part of the session, e.g. meal planning, shopping, etc. rather than merely stating that the group discussed eating a healthy diet. Further, the delivery of this service must be supported by impairments noted on the assessment

(or assessment addendum) indicating that this particular client needed assistance with this skill. The Service Plan must include specific skills that are barriers to the client reaching his/her desired outcome with these leading to specific skill development goals.

Group rehabilitation and group psychotherapy are both types of Mental Health Services and as such are reimbursed at the same rate. Activities of Daily Living/skill building is a Medi-Cal rehabilitation reimbursable activity. Healthy Living Groups are primarily rehabilitation/skill building groups that may be facilitated by either Licensed Practitioners of the Healing Arts (LPHAs) or non-LPHAs, e.g. substance abuse counselors. Because the service is rehabilitation, a Healthy Living Group should always be billed as a group rehabilitation regardless of who is delivering the service. If a group is lead exclusively by LPHA's and is primarily focused on psychotherapy with minimal skill development and documentation supports the service as predominantly psychotherapy it may be claimed as group psychotherapy.

12. Q: Are DMH sites required to use Eli Lilly's Solution for Wellness Group Program?

A: The goal of Healthy Living groups is to provide individuals who have co-occurring disorders the opportunity to explore healthy alternatives to unhealthy lifestyle choices. For example, subject matter might include healthier eating, exercise, hygiene, safe sex, and sleep habits as well as reduction of or abstinence from abused substances. Eli Lilly's module can serve as a guide, but does not address substance abuse. The Department does not prescribe any particular model, but does expect every site to offer a Healthy Living group for individuals with co-occurring disorders. (7/14/04)

13. How do I know if I have a Healthy Living group in my clinic?

A: The primary purpose of a Healthy Living group is to develop healthy living skills (proper nutrition, exercise, rest, socialization) via education about health, provision of suggestions about good lifestyle choices, review of relevant experiences and change attempts by group members, and motivating feedback conducted in a group setting. A healthy living group meets regularly (weekly) and lasts between one and two hours. It is generally led by at least one suitably trained staff member, but peer advocate and self-help models may play key roles in specific cases. It may have a set curriculum, or may be ad hoc. For easy recognition, the group is called a "Healthy Living" group or some close variant of that. In situations in which there is a question as to the degree to which a healthy living group meets the above criteria, the determination is made by the program manager in collaboration with the COD coordinator or supervisor. (8/10/04)